Attachment 4

CHILDREN'S SERVICES REFERRAL APPLICATION

Date of Referral:_____ Date Placement is Needed:_____

Type of Referral:

θ High Management
θ Supervised Independent Living
θ Residential Treatment Facility
θ Therapeutic Foster Care – Level 2
θ Temporary De-escalation Care–Level 1
θ Temporary De-escalation Care–Level 3
θ Temporary De-escalation Care–Level-MMGH
θ Moderate Management
θ Intensive Crisis Care
θ Therapeutic Foster Care – Level 1
θ Therapeutic Foster Care – Level 3
θ Temporary De-escalation Care–Level 2
θ Temporary De-escalation Care–Level-HMGH
θ Other:_____

Referring Agency: θ COC θ DDSN θ DJJ θ DMH θ DSS θ DSS-MTS
θ Other: _____

If client is in DSS custody, has the ISCEDC team approved placement? θ Yes θ No

Case Manager's Name:_____ Region:_____

Phone Number:_____ Fax Number:_____ E-Mail: _____

Address:_____

CLIENT INFORMATION

Client's Name:_____

Alias/Nickname:_____

Social Security Number:_____ Medicaid Number: _____

Medical Insurance Policy Carrier, Number(s), Holder:_____

Date of Birth: _____ Age: ____ Gender: _____ Race: _____ Height: _____ Weight: _____

Religious Affiliation: _____

Place of Birth:_____ County of Legal Custody:_____

Legal Custodian:_____ Relationship to Client:_____

Address:_____

Telephone Number:_____

Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.):_____

Hobbies: _____

Strengths: (Check all that apply)
θ Strong Family Base
θ Appropriate Reading Level
θ Average/Above IQ
θ On Grade-Level
θ Good Verbal Skills
θ Good Personal Hygiene
θ Good Socialization Skills
θ Appropriate Coping Skills
θ Other: _____

Reason for Referral: _____

CLIENT'S CURRENT PLACEMENT: _____

Type of Facility:
θ Supervised Independent Living
θ Residential Treatment Facility
θ Therapeutic Foster Care – Level 2
θ Temporary De-escalation Care–Level 1
θ Temporary De-escalation Care–Level 3
θ Temporary De-escalation Care–Level-MMGH
θ Moderate Management
θ Intensive Crisis Care
θ Therapeutic Foster Care – Level 1
θ Therapeutic Foster Care – Level 3
θ Temporary De-escalation Care–Level 2
θ Temporary De-escalation Care–Level-HMGH
θ Other: _____

Number of Previous Placements: θ0-3 θ4-6 θ7-10 θ More than 10

Placement History: Please list all placements including psychiatric hospitalizations. Attach additional page(s) if necessary.

Placement	Dates (From/To)	Reason for Discharge

CURRENT BEHAVIORAL PROBLEMS/WEAKNESSES (check all that apply): **If a behavior has an asterisk beside it, include an explanation of the circumstances/situation in the space below the chart.**

θ Abandonment Issues	θ Aggressive (Physical)	θ Aggressive (Sexual)
θ Aggressive (Verbally)	θ Alcohol/Drug Abuse	θ Antisocial Behavior
θ Anxiety	θ *Arson	θ *Bedwetting
θ Below Grade Level	θ Cruelty to Animals	θ Delusional
θ Depression	θ Destroys Property	θ Difficulty with Authority
θ *Developmentally Delayed	θ *Fire Setting	θ Functionally Illiterate
θ Eating Disorder	θ Hyperactive	θ Impulsive
θ Homeless	θ Loss/Grief Difficulties	θ *Low IQ/Mental Retardation
θ Low Self-Esteem	θ Oppositional/Defiant	θ Parental Neglect Issues
θ Phobic Reactions/Behavior	θ Physical Disability:	θ Poor Coping Skills
θ Poor Personal Hygiene	_____	θ □ Poor Reality Orientation
θ Poor Social Skills	θ Problems at School	θ Running Away
θ Self-Destructive Behavior	θ *Sexually Acts Out	θ Sexually Provocative
θ Sibling Related Difficulty	θ Suicidal Gestures	θ Suicidal Ideation
θ Steals	θ Truancy	θ Unruly/Ungovernable
θ Other:_____	θ Other:_____	θ Other:_____

Explanation: _____

_____

_____

_____

_____

_____

Client has been a victim of (check all that apply):

θNeglect	θ Abuse	θAllegation	θSubstantiated-Perpetrator: _____
θNeglect	θ Abuse	θAllegation	θSubstantiated-Perpetrator: _____
θNeglect	θ Abuse	θAllegation	θSubstantiated-Perpetrator: _____
θNeglect	θ Abuse	θAllegation	θSubstantiated-Perpetrator: _____

MEDICAL INFORMATION

DSM IV DIAGNOSIS: Diagnosis Date Given Source

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

MEDICATIONS (list all current medications, dosages, and instructions):

Medication Name Dosage Instructions

_____
_____
_____
_____
_____

List any known, pre-existing medical conditions/physical disabilities that would place the client at a greater risk during restraint or seclusion.

_____

_____

Describe any known history of sexual or physical abuse that would place the client at greater psychological risk during restraint or seclusion.

_____

_____

MEDICAL CONDITIONS (check all that apply): C = Current H = History of T = Being Treated for

Anemia	θC θH θT	Anorexia	θC θH θT	Asthma	θC θH θT
Bulimia	θC θH θT	Chicken Pox	θC θH θT	Convulsions	θC θH θT
Diabetes	θC θH θT	Eczema	θC θH θT	Encopresis	θC θH θT
Enuresis	θC θH θT	Fainting	θC θH θT	Hay Fever	θC θH θT
Headaches	θC θH θT	Hepatitis	θC θH θT	HIV/AIDS	θC θH θT
Lice	θC θH θT	Measles	θC θH θT	Mumps	θC θH θT
Pink Eye	θC θH θT	Pregnancy	θC θH θT	Ringworm	θC θH θT
Seizures	θC θH θT	Sinusitis	θC θH θT	Sore Throat	θC θH θT
STD(s)	θC θH θT	Tuberculosis	θC θH θT		θC θH θT

θC θH θT Other: (specify) _____
θC θH θT Other: (specify) _____
θC θH θT Other: (specify) _____

Date of Last Physical Exam: _____ Dental Exam: _____ Eye Exam: _____

Dental Appliances: θYes θNo Contacts/Glasses: θYes θNo

Allergies: _____

Special Dietary Needs: _____

FAMILY INFORMATION

Biological Mother's Name:_____

Address:_____

Telephone Number:_____

Race:_____ Educational Level (if known):_____Criminal Record: θYes θ No

Biological Father's Name:_____

Address:_____

Telephone Number:_____

Race:_____ Educational Level (if known):_____Criminal Record: θYes θ No

Are the Biological Parents: θMarried θSeparated θDivorced:
θDeceased (which one):_____ θOther:_____

Have Parental Rights Been Terminated? θNo θYes, date:_____

Name of Siblings: Placement: (If applicable)

FAMILY STRENGTHS

FAMILY CONTACT

Significant Family Member(s) and Relationship to Client	Address	Phone Number	Type of Contact with Client (phone, letters, face-to-face, etc.)

OTHER APPROVED CONTACTS

Name and Relationship to Client	Address	Phone Number	Type of Contact with Client (phone, letters, face-to-face, etc.)

Are there any special conditions/restrictions for home visits or furloughs? _____

There is a family history of (check all that apply):

θ Child Abuse/Neglect
θ Inappropriate Sexual Behavior
θ Treatment Disruption
θ Criminal Activity
θ Psychiatric Illness
θ Other: _____

Brief family history on education, behavior, development, adoption, psychosocial, legal (arson, stealing, sexual, burglary, and assault), parent's psychiatric history, etc.

SCHOOL INFORMATION (CONFIDENTIAL AND NONTRANSFERABLE)

Client Name: _____
Date of Birth: _____ Gender: _____ Race: ____ Legal Custodian: _____
Agency: _____ Case Manager Name: _____
Agency Address: _____
Phone: _____ Fax: _____ E-Mail: _____

Home School District of Origin: _____

List last five schools attended beginning with the most recent:

PLACEMENT	DATES		SCHOOL ATTENDED	DELIVERY MODEL (Select from the list below.)

Delivery models are: Homebased, Itinerant, Medical Homebound, Regular Education, Resource Room, and Self-contained Classroom

Is client currently classified Special Education? θNo θ* Yes (Indicate primary classification below.) θUnk

θ Preschool Child with a Disability
θ Mental Disability
θ Specific Learning Disability
θ Speech or Language Impairment
θ Autism
θ Deaf/Blindness
θ Emotional Disability
θ Hearing Impairment/Deafness
θ Multiple Disabilities
θ Orthopedic Impairment
θ Other Health Impairment
θ Traumatic Brain Injury
θ Visual Impairment

Has client ever been classified Special Education?	θNo	θYes	θUnk	
Does client have current IEP?	θNo	θYes	θUnk	IF YES, date: _____
Does client have section 504 Plan?	θNo	θYes	θUnk	IF YES, date: _____
Does client have history of truancy?	θNo	θYes	θUnk	
Has client ever been suspended?	θNo	θYes	θUnk	
Is client currently under recommendation for expulsion?	θNo	θYes	θUnk	For what? (Enter the reason in the

Is the client functioning at grade level? θNo θYes If below, please indicate grade level: _____

IQ/ACHIEVEMENT/ADAPTIVE TESTING

Name of Test	Date	Given By:	Scores and Ranges, e.g., Low. Average, etc.

Is the IQ score considered valid by the examiner? θ No θYes (If not, explain.) _____

Medical Conditions: _____

Current Medications: _____

This page is to be provided to the receiving school district along with the signed Authorization for Release of School Information

AGENCY/COURT INVOLVEMENT

AGENCIES CURRENTLY INVOLVED WITH CLIENT

θCCRS θCOC θDDSN θDJJ θDMH θDSS θDSS-MTS θVoc. Rehab
θOther: _____

Has the client ever been to court? θNo θYes-type of court and outcome: _____

Does the client have pending charges? θNo θYes-list charges: _____

Is placement court ordered? θNo θYes-attach copy of the order

TREATMENT GOALS

Client's Goals	
Family's Goals (if applicable)	
Agency's Goals	
Educational Goals	

ADMISSION REQUIREMENTS CHECKLIST
(TO BE FORWARDED IF CLIENT IS ACCEPTED FOR PLACEMENT)

The referring agency will make every reasonable effort to supply the items listed in the Admission Requirements Checklist if the client is accepted for placement. If more information than is provided in the Children's Services Referral Application is required to determine client eligibility for admission, the provider agency should request in writing the additional information from the referring agency.

ADMISSION REQUIREMENTS CHECKLIST (IF ACCEPTED FOR PLACEMENT)	
Medical Exam	θ
Most Recent Treatment Plan	θ
Current Medicaid /Insurance Card	θ
Medical Necessity Form	θ
254 Authorization Form	θ
Most Recent Psychological/Psychiatric Evaluation(s)	θ
Previous Placement Discharge Summary(ies)	θ
Individual Education Plan (if applicable)	θ
Copy of Birth Certificate	θ
Copy of Social Security Card	θ
Immunization Records	θ
Completed Consent Forms (Program should forward to referring agency prior to admission)	θ
Copies of Court Orders	θ
Signed Homebound Form (if applicable)	θ
Pre-Admission Assessment (if applicable)	θ

Name of Person Making Application: _____

Relationship to Client: _____ Telephone: _____

Address: _____

Signature: _____ Date: _____